ED Pain Management

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History

- 2007 Poisoning replaced MV as the leading cause of injury death to Arizonan's
- ED's increasing challenged
- Enforcement community began to take notice
- ASAP created their Prescription Initiative
- ED Forum July 2012

The Patients:

- Need help
- Need detox
- Demanding
- Psych component
- Argumentative
- Know how to manipulate the system
- Take extra time

The Challenge:

- True Pain Needs vs. Drug Seeker
- Candy man vs. Uncaring
- Bridge vs. Supplier
- Low physician satisfaction
- Increased nurse frustration
- Higher no-pay population

The idea:

- Treat acute exacerbations of chronic pain in those who are helping themselves.
- Help those who want to help themselves to follow-up with pain management.
- Don’t supply the drug seekers or drug diverters

The Team:

- ED Medical Director & 2nd ED physician
- ED Nursing Director & ED Nurses
- ED Case Management nurses
- ED Social Workers
- Hospital Senior Vice President (CNO)
- Hospital Compliance Officer
- Hospital Legal/Risk Management
- Hospital Director of Case Management
- Hospital Director of Pain Management

The goal:

Establish a high quality acute/emergency pain management framework for ED's which will enhance emergency pain management in and out of the ED as well as diminish visits by those who abuse the system

Building Consensus:

- ED care is not optimal care for chronic pain
- Unified front
- Admin support
- System to track
- Real time
- Place(s) to refer
- Physician feedback

Chronic Pain Definition:

Any health condition which requires ongoing narcotic or benzodiazepine pharmaceuticals for treatment

Chronic Pain Diagnoses:

Migraine

Back Pain

Fibromyalgia

Ovarian Cysts/Endometriosis

Abdominal Pain

Pelvic Pain

Joint pains

Dental Pain

The Patients:

- Un-educated
  - Want to help themselves
  - Culturally taught to use ED instead of PCP
    - Need assistance with outside resources
- Drug Seekers
  - Personal use
  - Diversion
- Prescription refills
- Not motivated

Drug Seeking Definition:

Drug-seeking patients include recreational drug abusers, addicts whose dependence occurred through abuse or the injudicious prescription of narcotics, and pseudoaddicts who have chronic pain that has not been appropriately managed.

Literature Support:

- Hanson, George. *The Drug Seeking Patient in the Emergency Room*. Emergency Medicine Clinics of North America. May 2005. (23). Number 2.

- Geiderman, J. *Keeping lists and naming names: habitual patient filed for suspected nontherapeutic drug-seeking patients.* Annals of Emergency Medicine. June 2003 (41). 873-81.

Guidelines

- Based off criteria developed by Washington State ED community
- Consensus document endorsed by ADHS, ACEP and AZENA
- Intended to help reduce inappropriate use of controlled substances
- Not intended to establish standards of care
- Educational tool
- Promising intervention
- Clinicians MUST use their clinical judgment

Guideline 1

When possible 1 medical provider provides RX for patient's chronic pain

- ED prescribers are not in a position to monitor effects of chronic opioid therapy.
- Recommendation from the American Pain Society

Guideline 2

Use the Prescription Drug Monitoring System

- Using the system will allow a prescriber to identify patients who might be doctor shopping

Guideline 3

Use of IM or IV controlled substances for chronic pain is discouraged.

- Should be avoided due to short duration and potential for addictive euphoria
- Special circumstances…If ED care has been coordinated with patient's primary

Guideline 4

ED's should not provide replacement RX for controlled substances that were lost, stolen, or destroyed.

- Patients who misuse RX report their RX were lost or stolen. Pain specialists stipulate in pain agreements with patients that lost pain medication will not be replaced. ED's should institute policy not to replace lost/stolen RX.

Guideline 5

ED's should not provide replacement doses of methadone for patients in a methadone tx program.

- Methadone has a long half life, patients who are in a daily treatment program will not go into withdrawal for 48 hours.
- Opioid withdrawal is not an emergency medical condition
- Prescriber should consider patient might have been with drawn from a program due to non-compliance

Guideline 6

Long acting or controlled released opioids should not be prescribed from the ED.

- This type of treatment requires monitoring which the ED medical provider cannot provide.

Guideline 7

Patients should provide identification to pharmacy filling the RX.

- Patients who divert can provide a fictitious name when registering in the ED and receive RX under the fictitious name
- Patients who provide false information should be reported to law enforcement.
- Exemption: traumatic events when identification was truly destroyed or not with the patient.

Guideline 8

ED's are encouraged to photograph patients who present without ID.

- Photographing improves patient safety by providing a means of positive ID of the patient being treated
- Could prove as a deterrent to providing false information

Guideline 9

ED's should coordinate care of patients who frequently visit the ED.

- ED care coordination involves contacting the primary care physician to notify them of the patient's over utilization of the ED and formulate an ED care plan
- Plan should stress the importance of seeing PMP for chronic medical conditions and pain mgt.

Guideline 10

ED's should maintain a list of clinics that provide pain mgt and primary care for all payer types.

- ED's should encourage patients to seek primary care in non-emergent care settings.
- Patients who over utilize ED's should be counseled and given a list of clinic resources.
- ED prescriber should not feel compelled to provide RX due to patient's lack of PMP.

Guideline 11

ED's should perform SBIRT referrals to patients with suspected RX abuse problems.

- ED's remain the healthcare safety net.
- SBIRT has the potential to help an individual identify patterns/habits that place them at risk.

Guideline 12

Administration of Demerol is discouraged.

- Demerol use has been shown to induce seizures through accumulation of toxic metabolite and long half life
- Failed to demonstrate benefit in the tx of common pain problems

Guideline 13

For exacerbation of chronic pain, the PMP should be contacted. Patient should receive only enough pills to last until the office opens.

- Opioid for exacerbation of chronic pain is discouraged.
- Prescribe only enough to get by
- Contact PMP or pharmacy to determine recent RX

Guideline 14

Prescriptions for acute injuries should not exceed 30 pills with no refills.

- Patients should receive only enough to get them to their follow up appointment with PMP or referral.
- Opt for the lowest dosages

Guideline 15

ED patients should be screened for substance abuse prior to prescribing for acute pain.

- Patients with a history of substance abuse are at an increase risk of developing opioid addiction when prescribed opioids for acute pain.
- Opt for a non-opioid regime first

Guideline 16

ED physician is required to evaluate pain, use clinical judgment when treating but is not required to provide controlled substances for tx.

- EMTALA does not require the provider to provide pain relief.
- Provide medical screening to determine the patient does not have a emergency medical condition.

Implementation:

- Sufficient time for over-communication
- Communicate start date well in advance
- Internal and external
- Let the community know

Communication/Collaboration:

- ED Physicians
- ED Guidance
- ED Leadership
- ED Patient Care Council
- Medical Executive Committee
- Hospital Administration

Summary:

- Treatment of chronic pain patients in the ED is challenging
- Progress can be made through:
  - Administration/nurse/MD collaboration
  - Unified front
  - Best patient care approach

ARIZONA MEDICAL ASSOCIATION

ADVANCING EMERGENCY CARE
Arizona College of Emergency Physicians

EMERGENCY NURSES ASSOCIATION
Arizona State Council

Arizona Department of Health Services

Prescribing Pain Medication in the Emergency Department

Our emergency department staff understand that pain relief is important when someone is hurt or needs emergency care. However, providing pain relief is often complex. Mistakes or misuse of pain medication can cause serious health problems and even death. Our emergency department will only provide pain relief options that are safe and appropriate.

- Our main job is to look for and treat an emergency medical condition. We use our best judgment when treating pain, and follow all legal and ethical guidelines.
- We may ask you to show a photo (such as a driver's license) when you check into the emergency department or receive a prescription for pain medication.
- We may ask you about a history of pain medication misuse or substance abuse before prescribing any pain medication.
- We may only provide enough pain medication to last until you can contact your doctor. We will prescribe pain medication with a lower risk of addiction and overdose when possible.
- **For your safety, we may not:**
  - Give pain medication shots for sudden increases in chronic pain.
  - Refill stolen or lost prescriptions for medication.
  - Prescribe missed methadone doses.
  - Prescribe long-acting pain medication such as OxyContin, MS Contin, fentanyl patches, or methadone for chronic, non-cancer pain.
  - Prescribe pain medication if you already receive pain medication from another doctor or emergency department. An exception may be made after a urine drug test or contact with your doctor or clinic.

If you would like help, we can refer you to a drug treatment program.
Or you can call the Arizona Recovery Help Line at **1.855.378.4435 (Toll free).**
http://www.addictionwithdrawal.com/arizona.htm